MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08212 08205

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	THOMAS	Middle (NMN)	Last BENTON
2a. DATE OF DEATH Month Day Year	June 3, 1969	2b. HOUR	1:15 A.M.
3. SEX	Male		
4. RACE	White		
5. DATE OF BIRTH	08-9-86		
6. AGE (In years last birthday)	82 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country)	Maryland		
7b. CITIZEN OF WHAT COUNTRY?	U.S.A.		
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐			
9. COUNTY OF DEATH	Carroll Md.		
10. CITY OR TOWN OF DEATH	Sykesville		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Springfield State Hospital		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Musician & Laborer		
12b. KIND OF BUSINESS OR INDUSTRY	Factory		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Baltimore City
13c. CITY OR TOWN	Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	107 Warren Avenue		
14. FATHER'S NAME First	William	Middle H.	Last Benton
15. MOTHER'S MAIDEN NAME First	Jennie	Middle	Last Day
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	No	16b. SOCIAL SECURITY NO.	213-20-0019 Unknown
17. INFORMANT Address	Records, Springfield State Hospital		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Possible Myocardial Infarct — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

DUE TO, OR AS A CONSEQUENCE OF

(b) Generalized Arteriosclerosis — years

DUE TO, OR AS A CONSEQUENCE OF

(c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from 4-19-51, 19____, to 6-3-69, 19____, that (I) (we) last saw the deceased alive on 6-3-69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Octavio A. Ruiz M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED 6-3-69
22d. PHYSICIAN'S NAME (Type)	Octavio Ruiz, M.D.	22e. ADDRESS	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	6/5/69	Oak Lawn Cemetery	Baltimore, Md.	
24. FUNERAL DIRECTOR ADDRESS	Schimunek Funeral Home, Inc. 3331 Brehms Lane	25a. REC'D BY REGISTRAR DATE	JUN 6 1969	25b. REGISTRAR'S SIGNATURE Charles Judge

VR A15 (M) 45M - 1-69

4 1

08213

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item23 Film414 7/18/69 kk

CERTIFICATE OF DEATH

08206

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
25M 1/67

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gamber
c. LENGTH OF STAY IN 1b: Lifetime
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): RD 2 Finksburg, Md.

2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Carroll
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Gamber
d. STREET ADDRESS:
e. IS RESIDENCE ON A FARM? YES [X] NO [ ]

3. NAME OF DECEASED (Type or print): First: Grace — Middle: Louisa — Last: Brauning

4. DATE OF DEATH: Month: June — Day: 28 — Year: 1969

5. SEX: Female

6. COLOR OR RACE: White

7. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]

8. DATE OF BIRTH: March 12, 1881

9. AGE (In years last birthday): 88 yrs.

IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Housewife

10b. KIND OF BUSINESS OR INDUSTRY:

11. BIRTHPLACE (County & State, or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Elias Shilling

14. MOTHER'S MAIDEN NAME: Emma Jane Davis

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown): No
(If yes give wor or dates of service):

16. SOCIAL SECURITY NO.:

17. INFORMANT: Mrs. David T. Young — Address: RD 2 Finksburg, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cardiac arrest — INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO (b): Hypertensive cardiovascular — INTERVAL BETWEEN ONSET AND DEATH: years
DUE TO (c): arteriosclerotic disease
4122
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)

19. WAS AUTOPSY PERFORMED? YES [ ] NO [X]

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURRED (Enter noture of injury in Port I or Port II of item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work [ ] Not While at work [ ]

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that (I) (this hospital) attended the deceased from 1-1-, 1940 to 6-28-69, 19, that (I) (we) last saw the deceased alive on 6-28-69, 19 69, and that death occurred at 7:10 P.M. from causes and on the date stated above.

22a. SIGNATURE: James G. Saffell — M.D. — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ]

22b. DATE SIGNED: 6-28-69

22c. PHYSICIAN'S NAME (Type): James G. Saffell

22d. ADDRESS: Reisterstown Md

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: July 2, 1969

23c. NAME OF CEMETERY OR CREMATORY: Providence Church Cemetery / Calvary Luth. Ch. Cemetery

23d. LOCATION (City or Town) (County) (State): Gamber Carroll Md.

24. FUNERAL DIRECTOR: Thomas D. Fletcher Funeral Home — ADDRESS: 254 East Main Street, Westminster, Md.

25a. RECD BY REGISTRAR DATE: JUL 8 1969

25b. REGISTRAR'S SIGNATURE:

1

08214

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08207

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Cora	Middle: -	Last: Brooks	2a. DATE OF DEATH: 6 Month 20 Day 69 Year	2b. HOUR: 2:30 pm M	
3. SEX: female	4. RACE: Negro	5. DATE OF BIRTH: 5/23/77	6. AGE (In years last birthday): 92 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country): Virginia	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.			
10. CITY OR TOWN OF DEATH: Rural--Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): housewife	12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 519 Lanvale Street		
14. FATHER'S NAME First: William	Middle	Last: Young	15. MOTHER'S MAIDEN NAME First: Eliza	Middle: -	Last: ?	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): no (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-54-6310T	17. INFORMANT: Springfield Hospital records	Address: Sykesville, Md.			

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Congestive heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
4270
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that ~~I~~ (this hospital) attended the deceased from 9/26/ 1963, to 6/20/ 1969, that ~~I~~ (we) last saw the deceased alive on 6/20/ 1969 and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 6/20/69		
22d. PHYSICIAN'S NAME (Type): Naci N. Buyukunsal, M.D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland		
23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6-21-69	23c. NAME OF CEMETERY OR CREMATORY: St Lukes Cemetery	23d. LOCATION (City or Town) (County) (State): Sykesville Md.
24. FUNERAL DIRECTOR: Harry W. Haight	ADDRESS: Sykesville, Md.	25a. REC'D BY REGISTRAR DATE: JUN 25 1969	25b. REGISTRAR'S SIGNATURE: [signature]

VR A15 (4) 45M - 1-69

1-4 08215

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Cora	Middle: L.	Last: Caldwell	2a. DATE OF DEATH: June Month 18 Day 1969 Year	2b. HOUR: 1 PM	
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: March 24, 1888	6. AGE (In years last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): York Co. Pa.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED [ ] NEVER MARRIED [*] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Carroll Co. Hospt.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: Manchester	13d. INSIDE CITY LIMITS? YES [ ] NO [*]	13e. STREET AND NUMBER: Rt. 1	
14. FATHER'S NAME First: James	Middle:	Last: Shenk	15. MOTHER'S MAIDEN NAME First: Kathryn	Middle:	Last: Burkholder
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 178-16-3080	17. INFORMANT: Howard E. Caldwell	Address: Rt. 1 Manchester, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): 4409
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
DUE TO, OR AS A CONSEQUENCE OF (b): Generalized Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [✓]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** thot (I) (this hospital) attended the deceased from June 4, 1969, to June 15, 1969, that (I) (we) last saw the deceased alive an June 15 1969, and that in (my) (our) opinion death accurred on the date ond haur and from the causes stated above, (I) (we) (did) (did not) view the bady ofter deoth.

22b. SIGNATURE: John S. Harshey, M.D. DEGREE	ATTENDING PHYS. [✓] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 6/18/69	
22d. PHYSICIAN'S NAME (Type): JOHN S. HARSHEY, M.D.	22e. ADDRESS: 8 Anchor St. Westminster, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 21, 1969	23c. NAME OF CEMETERY OR CREMATORY: Immanuel Cemetery	23d. LOCATION (City or Town): Manchester, Md.	(County) / (State)
24. FUNERAL DIRECTOR: Tipton - Eline Funeral Home	ADDRESS: Hampstead, Md.	25a. REC'D BY REGISTRAR DATE: JUN 23 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 M
45M - 1/69

1 4 08216

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08209

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
LEWIS	WILLIAM	CLAS	JUNE 20, 1969	8:50 A M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	7-30-1886	82 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH
Maryland	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Retired (farmer)	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	Manchester	NO [X]	Maplegrove Road

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Charles		Clas	Unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	218-32-5900A	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bronchopneumonia — Approximate interval between onset and death: Days

403 X

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Uremia — Days

DUE TO, OR AS A CONSEQUENCE OF (c) Renal failure due to nephrosclerosis — Months

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS assoc. with circulatory disturbance other than cerebral arteriosclerosis, with psychotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [X]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from 5-9-69, 19___, to 6-20-69, 19___, that (I) (we) last saw the deceased alive on 6-20-69 19___, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Dr. Antonius Glahn			[X]	6/20/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Antonius Glahn, M. D.	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 23, 1969	Immanuel Cemetery	Manchester, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tipton - Eline Funeral Home Hampstead, Md.	JUN 23 1969	Charles Judge

VR A15 (4) 45M - 1/69

4 1

08217

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08210

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death unless any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print) First: MARY AMANDA Middle: Last: CLICK				2a. DATE OF DEATH KNOWN ☐ ESTIMATED ☐ Month Day Year: June 15 1969	2b. HOUR: M
3. SEX: F	4. RACE: W	5. DATE OF BIRTH: FEB. 1, 1901	6. AGE (In years last birthday): 68 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS: HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year: JUNE 15 1969	2d. HOUR: 12:45 PM
7a. BIRTHPLACE (State or foreign country): PENNA.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH: CARROLL CO. Md.	
10. CITY OR TOWN OF DEATH: WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CARROLL CO. GENERAL	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): House-wife		12b. KIND OF BUSINESS OR INDUSTRY: —	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD.	13b. COUNTY: CARROLL	13c. CITY OR TOWN: WESTMINSTER	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: MEADOW BRANCH RD.	
14. FATHER'S NAME First: BERNARD Middle: ECKENRODE Last:		15. MOTHER'S MAIDEN NAME First: MARY Middle: Last: MYERS			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213-18-9963	17. INFORMANT: Earl N. Click	ADDRESS: Same address		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Fracture of skull — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 3/4 hrs

DUE TO, OR AS A CONSEQUENCE OF (b): auto accident

DUE TO, OR AS A CONSEQUENCE OF (c): —

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 8199

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☑
21a. EXTERNAL CAUSE WAS PRIMARY ☑ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. 1115 P.M. 6-15 1969	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.): auto accident
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☑	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.): Street	21f. LOCATION Street or R.F.D. No.: Meadow Branch Road City or Town: Rte 97 County: State:

22a. **I certify** that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☐, and in my opinion death resulted from: Natural causes ☐, Accident ☑, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Maurice C. Porter Jr. M.D.

EXAMINER'S NAME (Type): MAURICE C. PORTER, JR. M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☑

ADDRESS (Street, city, town, or county): HAMPSTEAD, MD

22b. DATE SIGNED: 6-15-69

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/18/69	23c. NAME OF CEMETERY OR CREMATORY: MT. VIEW CEMETERY	23d. LOCATION (City or Town): EMMITSBURG	(County): (State): MD.
24. FUNERAL DIRECTOR: E. E. Myers Jr.	ADDRESS: Westminster, Md.	25a. REC'D BY REGISTRAR DATE: JUN 18 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15ME (5) 10M REV. 1/68

1

08218

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08211

Item#14, FilmG414 7/9/69 km

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Kate		Cooper	June	28	1969	5:40 M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
female	White	Aug 30, 1880	88 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Balto Md	U S A	WIDOWED ☑	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
MAnchester, Md	Long View Nursing Home	Housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md	Baltimore Co	Hampstead	YES ☐ NO ☐ *	Long View Beechlynne Rd.

14. FATHER'S NAME First / Middle / Last	15. MOTHER'S MAIDEN NAME First / Middle / Last
Melvin Cooper Frank D. Resh	Adella Armacost

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
NO	216-46-3881	Kathryn M. Miller	Hampstead, Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 min
DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 5 yrs
DUE TO, OR AS A CONSEQUENCE OF (c)

4109
Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes mellitus

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this haspitol) attended the deceased from 7/3, 19 67, to 6/28, 19 69, that (I) (we) last saw the deceased olive on 6/27 19 69, and thot in (my) (our) opinion deoth occurred on the date and haur and from the couses stoted above, (I) (we) did (did not) view the bady ofter death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
W H Foard		☑	☐	☐	6/28/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
W. H Foard MD	Manchester, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	July 1, 1969	Grace Cemetery	Hampstead Balto. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tipton - Elline Funeral Home	Hampstead, Md.	JUL 7 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08219 — 08212

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	MAMIE ELIZABETH DIX	2a. DATE OF DEATH Month / Day / Year	6 / 28 / 69
2b. HOUR	7:4. M		
3. SEX	FEMALE	4. RACE	WHITE
5. DATE OF BIRTH	FEB. 3, 1894	6. AGE (In years last birthday)	75 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	VIRGINIA	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH	CARROLL Co. Md.
10. CITY OR TOWN OF DEATH	RD#6 WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	OLD WASHINGTON Rd.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	HOUSE-WIFE	12b. KIND OF BUSINESS OR INDUSTRY	—
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MD.	13b. COUNTY	CARROLL
13c. CITY OR TOWN	WESTMINSTER	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	
13e. STREET AND NUMBER	RD #6		
14. FATHER'S NAME First / Middle / Last	RUFUS MONTGOMERY HORNE	15. MOTHER'S MAIDEN NAME First / Middle / Last	LIZZIE NEFF
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.	220-30-7708
17. INFORMANT	TANDY A. DIX	Address	SAME ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Chronic Pulmonary Tuberculosis — Interval: Several Yrs
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerotic Heart Disease — Interval: Several Yrs
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 011.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 5-4, 1963, to 6-28, 1969, that (I) (we) last saw the deceased alive on 6-30-1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. dr Chesky seen in my absence

22b. SIGNATURE (DEGREE) Wm. Speichel MD — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED 6/30/69

22d. PHYSICIAN'S NAME (Type) — 22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
BURIAL	7/1/69	EVERGREEN MEM. GARDENS	FINKSBURG	MD
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
J. E. Myers Jr.	Westminster, Md.	JUL 2 1969	J. Charles Judge	

VR A15 (4) 30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08220 — 08213

1. DECEASED-NAME (Type or print): First MAYMIE Middle ELIZABETH EDITH Last DIXON
2a. DATE OF DEATH: Month JUNE Day 11 Year 69
2b. HOUR: 12:15 A.M.
3. SEX: FEMALE
4. RACE: COLORED
5. DATE OF BIRTH: JULY 4, 1905
6. AGE (In years last birthday): 63 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL Co. Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 36 CHARLES ST
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): HOUSE-WIFE
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE: MARYLAND
13b. COUNTY: CARROLL
13c. CITY OR TOWN: WESTMINSTER
13d. INSIDE CITY LIMITS? YES ☐ NO ☐
13e. STREET AND NUMBER: 36 CHARLES ST.
14. FATHER'S NAME: First SIMEON Middle Last JOHNSON
15. MOTHER'S MAIDEN NAME: First ELSIE Middle Last DUNSON
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service):
16b. SOCIAL SECURITY NO.: 215-32-3654
17. INFORMANT: THOMAS A. DIXON Address: SAME ADDRESS

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Carcinoma Lungs (Metastasis) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 5-6 yrs
DUE TO, OR AS A CONSEQUENCE OF (b): Cachexia & Anemia — 6 mo to 1 yr
DUE TO, OR AS A CONSEQUENCE OF (c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
1621

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☐
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from 11-5-64, 1964, to 6-11, 1969, that (I) (we) last saw the deceased alive on 6-10 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W. Glenn Speicher MD — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 6-11-69
22d. PHYSICIAN'S NAME (Type): W. GLENN SPEICHER M.D.
22e. ADDRESS: Westminster Md

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 6/14/69
23c. NAME OF CEMETERY OR CREMATORY: MT JOY CEMETERY
23d. LOCATION (City or Town) (County) (State): UNIONTOWN CARROLL MD.
24. FUNERAL DIRECTOR: J. S. Myers Jr. ADDRESS: Westminster, Md.
25a. REC'D BY REGISTRAR DATE: JUN 13 1969
25b. REGISTRAR'S SIGNATURE: J. Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

08221

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08214

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR	
BARBARA	(NMN)	DONOHUE	JUNE 5, 1969	6:00 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Female	White	7-22-17	51 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH		
Maryland	U.S.A.		Carroll Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville	Springfield State Hospital	None			
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER	
Maryland	Baltimore City	Baltimore		1646 Jackson St.	
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
John	J.	Blottenberger	Anna	M.	Carlisle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address		
No	-----	Records, Springfield State Hospital			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive infarction of left ventrical of heart due to embolism. — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: minutes

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

DUE TO, OR AS A CONSEQUENCE OF (b) Infarcts in right hemisphere of brain due to embolism. — less than a day.

DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-11-34, 19___, to 6-5-69, 19___, that (I) (we) lost saw the deceased olive on 6-5-69 19___, and thot in (my) (aur) opinion deoth occurred on the dote and haur and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Dr. Antonius Glahn	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	6-5-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Antonius Glahn, M. D.	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6 7 69	Glen Haven	Glen Burnie, A. A. Co. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Mc Cully	130 E. Fort Ave	JUN 9 1969	Charles Judge

VR A15 (4) 45M - 1-69

08222

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item14 Film G413 6/18/69 kk

CERTIFICATE OF DEATH

08215

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
JESSIE	W.	DORSEY	6 6 69	3:20 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
FEMALE	WHITE	6-26-1878	90 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
VIRGINIA	USA	WIDOWED ☒	CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
SYKESVILLE	Pullen Nursing Home	HOUSEWIFE	At Home.

13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Howard	Ellicott City	YES ☐ NO ☒	8099 Park Dr.

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Ambrose	Souder	Dorsey			Waters

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown)	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
No			Snowden Dorsey	8099 Park Dr Ellicott City

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Pulmonary Edema	12 hrs.
DUE TO, OR AS A CONSEQUENCE OF (b)	Chronic Heart Failure	10 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c)	CASCVD	20 yrs.

4124

Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	Stote

22a. I **certify** thot (I) (this hospital) attended the deceased from May 5, 1969, to June 5, 1969, that (I) (we) last saw the deceased alive on June 5 1969, and that in (my) (aur) apinian death occurred an the date and haur ond from the couses stoted above, (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Sani Okutman		☒	☐	☐	6/6/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Sani Okutman, M.D.	Obrecht Rd., Sykesville, Md. 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (Stote)
Burial	6-9-69	Woodlawn	Woodlawn Balto, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Higinbotham-Slack	Ellicott City, Md.	JUN 11 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 haurs after death. Page 4 may be retained by the haspital ar attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carban papers (Pages 2 and 3) should be filed with the State Dept. of Health priar to burial, cremation, ar removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

Items 5,6 Film G 414 MARYLAND STATE DEPARTMENT OF HEALTH Items2&23 FilmG413 6/20/69kk
7/3/69 llw DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE HEALTH DEPT.

08223

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08216

1. DECEASED-NAME (Type or Print) First	Middle	Last	2a. DATE KNOWN OF DEATH / ESTIMATED	Month	Day	Year	2b. HOUR
STANLEY	A.	ERICKSON		6	11	1969	M

3. SEX	4. RACE	5. DATE OF BIRTH	AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.	2c. DATE PRONOUNCED DEAD: Month / Day / Year	2d. HOUR
Male	White	Aug 19 1924	47 41 YRS.			June 11 1969	8:00 P.M.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
MINN.	U.S.A.	Separated	CARROLL Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	3 East Main - Apt.5	Merchant Seaman	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Carroll	Westminster	YES ☑ NO ☐	3 E. Main - Apt. 5

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
EMILE		ERICKSON	AGNES		FREEBURG

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	(If yes, give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	ADDRESS
YES	KOREAN WAR	470-26-0682	MRS. GRACE E. WARREN,	3E. MAIN ST. WESTMINSTER MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Fatty metamorphosis of liver — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5718
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY?
		YES ☒ NO ☐

21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☒, Inspection ☐, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE Charles S. Springate M.D.

EXAMINER'S NAME (Type) Charles S. Springate, M.D.

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☒
DEPUTY MEDICAL EXAMINER ☐
ADDRESS(Street, city, town, or county)

22b. DATE SIGNED June 12, 1969

23a. BURIAL (CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
REMOVAL	6/12/69	MT. SALEM CEMETERY	MANTONA CARROLLTON MINN

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
J. E. Myers Jr.	Westminster, Md.	JUN 16 1969	Charles Judge

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any deloy is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funerol director. Page 4 should be forworded to the Chief Medicol Exominer's Office along with form DM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as o burial-tronsit permit. File pages 1 ond 2 with the State Department of Health prior to burial, cremotion, or removol, ond in any event within 72 hours after death.

VR A15ME (5)
10M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08224 08217

1. DECEASED-NAME (Type or print): First Marion; Middle Hoppel; Last Fiery
2a. DATE OF DEATH: Day 6; Month 12; Year 69
2b. HOUR: 9:30 AM
3. SEX: female
4. RACE: white
5. DATE OF BIRTH: 7/15/96
6. AGE (In years last birthday): 72 YRS. IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN
7a. BIRTHPLACE (State or foreign country): Maryland
7b. CITIZEN OF WHAT COUNTRY?: USA
8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Rural--Sykesville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Springfield State Hospital
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Librarian
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY:
13c. CITY OR TOWN: Baltimore
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 6206 Mossway
14. FATHER'S NAME: First John; Middle -; Last Fiery
15. MOTHER'S MAIDEN NAME: First ~~Susan~~ Sue; Middle -; Last Hoppel
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service): no
16b. SOCIAL SECURITY NO.: 212-42-7328
17. INFORMANT: Address: Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebral hemorrhage — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day
DUE TO, OR AS A CONSEQUENCE OF
(b): Hypertension — years
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if ony, which gove rise to immediote couse (a), stoting the underlying couse lost.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Schizophrenic reaction, chronic undifferentiated type. CBS with cerebral arteriosclerosis.

19a. DATE OF OPERATION:
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED:
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that ☒ (this hospitol) ottended the deceosed from 9/26/, 19 66, to 6/12/, 19 69, thot ☒ (we) last saw the deceased alive on 6/12/ 19 69, and that in ☒ (our) opinion deoth occurred on the dote and haur and fram the causes stated above, ☒ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE: [signature] DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒
22c. DATE SIGNED: 6/12/69
22d. PHYSICIAN'S NAME (Type): Jose L. Chapulle, M.D.
22e. ADDRESS: Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-14-1969
23c. NAME OF CEMETERY OR CREMATORY: Rose Hill Cemetery
23d. LOCATION (City or Town) (County) (State): Hagerstown, Maryland
24. FUNERAL DIRECTOR ADDRESS: Wm. Cook-Brooks Towson 1050 York Rd. 21204
25a. REC'D BY REGISTRAR DATE: JUN 16 1969
25b. REGISTRAR'S SIGNATURE: [signature]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

08225

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08218

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Lula	Middle: C.	Last: Fleming	2a. DATE OF DEATH Month 6 Day 2 Year 69
2b. HOUR: 5 a.m.			
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Jan. 8, 1890	6. AGE (In years last birthday): 79 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Woodbine	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Route 1	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Woodbine	13d. INSIDE CITY LIMITS? YES ☐ NO ☒
13e. STREET AND NUMBER: Route 1			
14. FATHER'S NAME First: Jeff	Middle	Last: Campbell	15. MOTHER'S MAIDEN NAME First: Loretta Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: yes	17. INFORMANT: Raymond O. Fleming	Address: Same As #13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary occlusion — Approximate interval between onset and death: Sudden

DUE TO, OR AS A CONSEQUENCE OF

(b) HASCVD — 10 yrs.

DUE TO, OR AS A CONSEQUENCE OF

(c) Chronic Heart Failure — 10 yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4100

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

CA of nose

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from May 22, 19 69, to June 2, 19 69, that (I) (we) last saw the deceased alive on May 22 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Sani Okutman	DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: June 2, 1969	
22d. PHYSICIAN'S NAME (Type): Sani Okutman, M.D.	22e. ADDRESS: Obrecht Road, Sykesville, Md. 2178[illegible]		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/5/1969	23c. NAME OF CEMETERY OR CREMATORY: Morgan Chapel	23d. LOCATION (City or Town) (County) (State): Carroll, Md.	
24. FUNERAL DIRECTOR: C. M. Waltz, Box 241, Sykesville, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: JUN 5 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08226

08219

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Raymond	Middle: D.	Last: Flickinger	
2a. DATE OF DEATH Month: June Day: 29 Year: 1969	2b. HOUR: 9:20 P.M.		
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: Feb 3-1886	6. AGE (In years last birthday): 83 YRS. IF UNDER 1 YEAR: MONTHS / DAYS; IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: USA.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Manchester	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Long View Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY: Farmer
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY: Carroll	13c. CITY OR TOWN: New Windsor	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: RFD 2
14. FATHER'S NAME First: Rufus	Middle:	Last: Flickinger	15. MOTHER'S MAIDEN NAME First: Olivia	Middle:	Last: Albaugh
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-34-2344	17. INFORMANT: Mrs. Raymond Flickinger	Address: New Windsor, Md.	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 6 weeks
DUE TO, OR AS A CONSEQUENCE OF
(b): Generalized Arteriosclerosis — 5 yrs
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 436.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this haspital) attended the deceased from 6/6, 1969, ta 6/29, 1969, that (I) (we) last saw the deceased alive on 6/29 1969, and that in (my) (aur) apinian death accurred an the date and haur and fram the causes stated abave. (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: W H Foard MD	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED: 6/29/69	
22d. PHYSICIAN'S NAME (Type): W. H Foard MD	22e. ADDRESS: Manchester, Md 21102		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 7/2/1969	23c. NAME OF CEMETERY OR ~~CREMATORY~~: Mt. Hope	23d. LOCATION (City or Town) (County) (State): Woodsboro, Frederick, Md.	
24. FUNERAL DIRECTOR: C. M. Waltz	ADDRESS: Box 241, Sykesville, Md.	25a. REC'D BY REGISTRAR DATE: JUL 2 1969	25b. REGISTRAR'S SIGNATURE: [signature]	

VR A15(M)
30M REV. 1/68

4 1

08227

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08220

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health priar to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Mattie	Middle: May	Last: Fowble	2a. DATE OF DEATH Month: 6 Day: 12 Year: 69	2b. HOUR: 9 A.M. 20
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: 3-1-1882	6. AGE (In years last birthday): 87 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Md.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Manchester	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): 125 N. main St Longview Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md	13b. COUNTY: Carroll.	13c. CITY OR TOWN: Hampstead	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	13e. STREET AND NUMBER: 367 N. main ST.	
14. FATHER'S NAME First: Thomas	Middle	Last: Maitlin	15. MOTHER'S MAIDEN NAME First: Laura	Middle:	Last: Hampshire
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): no. (If yes give wor or dates of service)	16b. SOCIAL SECURITY NO.: 215-48-8243.	17. INFORMANT: Elsie Bodenzie (daughter)	Address: 367 main ST Hampstead Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Uremic Myocarditis
DUE TO, OR AS A CONSEQUENCE OF
(b): Arteriosclerotic Cardiovascular Disease
DUE TO, OR AS A CONSEQUENCE OF
(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4124

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County / State

22a. **I certify** that (I) (this hospital) attended the deceased from June 10, 1966, to June 12, 1969, thot (I) (we) last saw the deceased alive on June 10, 1969, and that in (my) (our) opinion death occurred an the date and hour and fram the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Ralph E. Bushong	DEGREE: ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED: June 12, 1969	
22d. PHYSICIAN'S NAME (Type): Joseph E. Bushong MD	22e. ADDRESS: Maryland Maryland				

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: June 15, 1969	23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State): Greenmount Carroll Md.	
24. FUNERAL DIRECTOR: Tipton - Eline Funeral Home	ADDRESS: Hampstead, Md.	25a. REC'D BY REGISTRAR: JUN 17 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

VR A15 (4) 30M REV. 1/68

1

08228

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08221

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
RITA	CATHERINE	GARLITZ	6	8	69	7:30 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
F	W	JUNE 29, 1918	50 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
PA.	USA		CARROLL CO. Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
NEW WINDSOR	RT #1, Box 118	HOUSEWIFE	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
MD.	GARRETT	LONACONING	YES ☐ NO ☒	R.D. 1

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
JOSEPH	A.	FAY			SPOHN

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	—	HARRY GARLITZ, R.D.1, LONACONING, MD.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Probable Myocardial Infarction	Unknown
DUE TO, OR AS A CONSEQUENCE OF (b)	Arteriosclerosis	
DUE TO, OR AS A CONSEQUENCE OF (c)	Progressive debility.	

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Physcosis, Senile Mental retardation.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from March, 19 69, to June, 19 69, that (I) (we) last saw the deceased alive on June 19 69, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (~~did~~) (~~did not~~) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
William R Rourke	MD	☒	☐	☐	6/8/69.

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
WILLIAM R. O'ROURKE MD	W. MAIN ST. WESTMINSTER MD

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6/11/69	ST. ANN'S CHURCH CEM.	R.D. LONACONING GARRETT, MD

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Koch Newman	Grantsville, Md.	JUN 13 1969	William Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1-69

1

08229

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08222

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper sheets 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: Florence	Middle: Thompson	Last: Glass	2a. DATE OF DEATH Month: June	Day: 1	Year: 1969	2b. HOUR: M
3. SEX: female	4. RACE: White	5. DATE OF BIRTH: Jan 2 - 1894	6. AGE (In years last birthday): 75 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Rose Hill, VA.	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.				
10. CITY OR TOWN OF DEATH: Manchester	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Long View Nursing Home	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Taneytown	13d. INSIDE CITY LIMITS? YES ☐ NO ☑	13e. STREET AND NUMBER: R. #1			
14. FATHER'S NAME First: Floyd	Middle: Thompson	Last	15. MOTHER'S MAIDEN NAME First: Victoria	Middle: MARTIN	Last: ~~Bupust~~		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No	(If yes give war or dates of service): No	16b. SOCIAL SECURITY NO.: 217-12-2291	17. INFORMANT: Artie Miller	Address: Keymar Village, Taneytown, Md			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 weeks
DUE TO, OR AS A CONSEQUENCE OF
(b): generalized Arteriosclerosis — 5 yrs.
DUE TO, OR AS A CONSEQUENCE OF
(c):

4369
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 5/15, 1969, to 6/1, 1969, that (I) (we) last saw the deceased alive on 5/30 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
W. H. Foard	M.D.	☑	☐	☐	6/1/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
W. H. Foard M.D.	Manchester, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
BURIAL	6-4-69	KEYSVILLE CEMETERY	KEYSVILLE, CARROLL, MD.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C.O. Fuss & Son	Taneytown, Md.	JUN 3 1969	Wesley Judge

VR A15 (4)
30M REV. 1-68

1

FOR STATE HEALTH DEPT.

08230

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08223

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH
a. COUNTY: Carroll
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Sykesville
c. LENGTH OF STAY IN 1b: 1 day
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Springfield State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY:
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore City 21211
d. STREET ADDRESS: 1127 W. 40th Street
e. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First ARTHUR Middle LAWRENCE Last GORSUCH

4. DATE OF DEATH: Month June Day 27 Year 1969

5. SEX: M

6. COLOR OR RACE: W

7. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 1-16-14

9. AGE (In years last birthday): 55 yrs.
IF UNDER 1 YEAR: Months / Days
IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): Sheet Metal Worker

10b. KIND OF BUSINESS OR INDUSTRY: C.E.Parsons

11. BIRTHPLACE (State or foreign country): Maryland

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME: Walter Gorsuch, dec.

14. MOTHER'S MAIDEN NAME: Charlotte Phillips, dec.

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown): No
(If yes give war or dates of service):

16. SOCIAL SECURITY NO.: 216-14-4347

17. INFORMANT: Springfield State Hosp. Records
Address:

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b):
DUE TO (c):

INTERVAL BETWEEN ONSET AND DEATH: Minutes

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART 1(a)

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. EXTERNAL CAUSE WAS PRIMARY ☐ or CONTRIBUTING ☐ CAUSE OF DEATH.

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)

20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. I certify that I took charge of the remains described above, held an Autopsy ☐, Inspection ☑, Inquiry ☑, and in my opinion death resulted from: Natural causes ☑, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: Maurice C. Porterfield M.D.

EXAMINER'S NAME (Type): MAURICE C. PORTERFIELD

CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☐
Address (Street, city, town, or county):

22. DATE SIGNED: 6-28-69

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: 7/1/69

23c. NAME OF CEMETERY OR CREMATORY: Poplar Springs Cem.

23d. LOCATION (City, town or county) (State): Howard Co., Md.

24. FUNERAL DIRECTOR: Ann Donovan - 3818 Roland Ave.
ADDRESS:

25a. REC'D BY REGISTRAR DATE: JUL 1 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15ME
3500 4-64

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08231 08224

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Viola	Irene	Grimes	6 Month 23 Day 69 Year	9:20 AM PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
female	white	8/15/99	69 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Maryland	USA		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	housewife	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.	Carroll	Sykesville	YES ☐ NO ☒	Route #2

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Thomas	-	Franklin	Rosie	-	Young

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	218-14-0068	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Massive hemorrhage in pericardial sac — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Minutes

441.0

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Perforated dissecting aneurysm of aorta — Months

DUE TO, OR AS A CONSEQUENCE OF (c) Chronic rheumatic and arteriosclerotic heart disease — Years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☒ NO ☐	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ☒ (this hospital) attended the deceased from 1/13/ , 1967 , to 6/23/ , 1969 , that ☒ (we) last saw the deceased alive on 6/23/ 1969 , and that in ☒ (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) ☐ view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Naci N. Buyukunsal	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	6/23/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Naci N. Buyukunsal, M.D.	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/25/1969	Ebenezer Cemetery	Winfield, Carroll, Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C. M. Waltz, Box 241, Sykesville, Md.	JUN 26 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4-45M - 1/68)

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08232 08225

1. DECEASED-NAME (Type or print)	First: Rose	Middle:	Last: Harty	2a. DATE OF DEATH Month: June	Day: 12	Year: 1969
2b. HOUR	3:45 PM					
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN	
Female	White	Sept. 16, 1882	86 YRS.			
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH			
Penna.	U.S.A.		Carroll County, Md.			
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY			
Taneytown	Crouse Mill Road	Housewife	Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER		
Maryland	Carroll	Taneytown,		Crouse Mill Road		
14. FATHER'S NAME First / Middle / Last		15. MOTHER'S MAIDEN NAME First / Middle / Last				
John Starrs		Sarah Mossey				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address				
No	179-38-4372	Mrs. A.G.Robbins, 1139 Rittenhouse Rd. Phila. Pa.				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Uremia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 mo

2509

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Arterio-Sclerosis Generalized — 5 yrs

DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes Mellitis — 7 yrs

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

Senility — Acute Glaucoma

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that (I) (this hospital) attended the deceased from June, 19 64, to June 12, 19 69, that (I) (~~we~~) last saw the deceased alive on June 12 19 69, and that in (my) (~~our~~) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
E. Ambler Thompson	M.D.	☑	☐	☐	6-12-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
E. Ambler Thompson, M.D.	Taneytown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/14/69	Holy Cross Cemetery	Philadelphia, Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
C.O.Fuss & Son	Taneytown, Maryland	JUN 16 1969	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

1

08233

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08226

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: HERBERT; Middle: ; Last: HORSEY	2a. DATE OF DEATH Month: JUNE; Day: 18; Year: 69	2b. HOUR: 8:15 M	
3. SEX: Male	4. RACE: Colored	5. DATE OF BIRTH: Jan. 30, 1897	6. AGE (In years last birthday): 72 YRS. (IF UNDER 1 YEAR: MONTHS, DAYS; IF UNDER 24 HRS.: HOURS, MIN)
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Route 3	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer	12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Sykesville	13d. INSIDE CITY LIMITS? YES [ ] NO [X]
13e. STREET AND NUMBER: Route 3			
14. FATHER'S NAME First: Harvey; Middle: ; Last: Horsey	15. MOTHER'S MAIDEN NAME First: Florence; Middle: ; Last: Johnson		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 220-01-3460A	17. INFORMANT: Mrs. Nina Horsey	Address: Same As # 13

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CARDIAC FAILURE (LEFT VENT.) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 HRS.
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4122
DUE TO, OR AS A CONSEQUENCE OF (b): HYPERTENSIVE A.S.C.V.D. — 10 YRS.
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [ ] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, natify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from JUNE, 1964, to JUNE, 1969, that (I) (we) last saw the deceased alive on JUNE 18 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: R. V. Houck Jr., M.D. DEGREE — ATTENDING PHYS. [X] MED. DIRECTOR [ ] STAFF PHYS. [ ] — 22c. DATE SIGNED: 6-18-69.

22d. PHYSICIAN'S NAME (Type): Dr. R. V. Houck, Jr. — 22e. ADDRESS: Liberty Rd., Sykesville, Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/21/1969	23c. NAME OF CEMETERY OR CREMATORY: Johnsville Cemetery	23d. LOCATION (City or Town) (County) (State): Johnsville, Carroll, Md.	
24. FUNERAL DIRECTOR: C. M. Waltz, Box 241, Sykesville, Md.	ADDRESS	25a. REC'D BY REGISTRAR DATE: JUN 23 1969	25b. REGISTRAR'S SIGNATURE	

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

08234

CERTIFICATE OF DEATH

08227

1. PLACE OF DEATH
a. COUNTY: Carroll — MARYLAND
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Henryton
c. LENGTH OF STAY IN 1b: 2,448 days
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address): Henryton State Hospital

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)
a. STATE: Maryland
b. COUNTY: Balto.
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town): Baltimore
d. STREET ADDRESS: 6309 Banbury Road
a. IS RESIDENCE ON A FARM? YES ☐ NO ☒

3. NAME OF DECEASED (Type or print): First: William — Middle: Townsend — Last: Hughes

4. DATE OF DEATH: Month: June — Day: 13 — Year: 1969

5. SEX: Male

6. COLOR OR RACE: White

7. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐

8. DATE OF BIRTH: 11-10-11

9. AGE (In years last birthday): 57 yrs. — IF UNDER 1 YEAR: Months / Days — IF UNDER 24 HRS.: Hours / Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): None

10b. KIND OF BUSINESS OR INDUSTRY: None

11. BIRTHPLACE (County & State, or foreign country): Baltimore, Maryland

12. CITIZEN OF WHAT COUNTRY? USA

13. FATHER'S NAME: Harry Scott Hughes

14. MOTHER'S MAIDEN NAME: Mary Elizabeth Wells

15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unkown) (If yes give war or dates of service): No

16. SOCIAL SECURITY NO.: None

17. INFORMANT: Mr. Irving Wells, 6309 Banbury Road, Address Balto., Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]

PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Profuse bleeding upper GI Tract — INTERVAL BETWEEN ONSET AND DEATH

5339

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO (b): Recurrent Peptic ulcer
DUE TO (c):

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a): Mental Retardation, congenital, severe

19. WAS AUTOPSY PERFORMED? YES ☐ NO ☒

20a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)

20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)

20c. TIME OF INJURY: Hour a.m. p.m. — Month, Day, Year 19

20d. INJURY OCCURRED While at work ☐ Not While at work ☐

20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)

20f. (City or town) (County) (State)

21. **I certify** that (I) (this hospital) attended the deceased from 10-1-62, 19..., to 6-13-, 1969, that (I) (we) last saw the deceased alive on June 13 1969, and that death occured at 10P M, from the causes and on the date stated above.

22a. SIGNATURE: Edgars M. Maculans M.D.

ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐

22b. DATE SIGNED: 6-14-69

22c. PHYSICIAN'S NAME (Type): Edgars M. Maculans, M. D.

22d. ADDRESS: Henryton, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial

23b. DATE THEREOF: June 18, 1969

23c. NAME OF CEMETERY OR CREMATORY: London Park Cem.

23d. LOCATION (City, town or county) (State): Baltimore, Md.

24. FUNERAL DIRECTOR'S SIGNATURE AND ADDRESS: John Burns' Sons, Towson, Md.

25a. REC'D BY REGISTRAR DATE: JUN 19 1969

25b. REGISTRAR'S SIGNATURE: Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/60

1

08235

08228

08228

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
ARTHUR	LEON	JOHNSON, SR.	6	4	69	11:00 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS. HOURS	MIN
Male	Negro	09/23/1882	86 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH
Virginia	U.S.A.		Carroll County Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Waiter	Restaurant

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER
Maryland	---	Baltimore		3031 Gwynn Falls Pkwy

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
unknown			unknown		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT	Address
yes/Navy/ WW I	217-01-0711-A	Springfield State Hosp.,	Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Arteriosclerotic heart disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: yrs.

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Pyelonephritis — days/wks

DUE TO, OR AS A CONSEQUENCE OF (c) Infected decubitus ulcers

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)

CBS assoc. with senile brain disease with psychotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that ~~I~~ (this hospital) attended the deceased from 09/06/67, 19 67, to 06/04, 19 69, that ~~I~~ (we) last saw the deceased alive on 06/04/69 19 ___, and that in ~~my~~ (our) opinion death occurred on the date and hour and from the causes stated above, ~~I~~ (we) (did) ~~did not~~ view the body after death.

22b. SIGNATURE DEGREE	ATTENDING PHYS. ☐	MED. DIRECTOR ☐	STAFF PHYS. ☒	22c. DATE SIGNED
Milton Buschman, MD				6/5/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Milton H. Buschman, M.D.	Springfield State Hosp., Sykes., Md.

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6-9-69	Arbutue Mem-Park	Baltimore Co., Md

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
I.L.Brown & Son 108-W-Montgomery Street	JUN 10 1969	J. Charles Judge

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08236 08229

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: WILLIAM Middle: MURRAY Last: KING	2a. DATE OF DEATH Month: JUNE Day: 11 Year: 1969	2b. HOUR: 12 AM	
3. SEX: MALE	4. RACE: WHITE	5. DATE OF BIRTH: SEPT. 23, 1893	6. AGE (In years last birthday): 75 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL CO. Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): RD#2	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): WORKER FOR LUMBER & COAL Co.	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MARYLAND	13b. COUNTY: CARROLL	13c. CITY OR TOWN: WESTMINSTER	13d. INSIDE CITY LIMITS? YES ☐ NO ☑ — 13e. STREET AND NUMBER: RD#2
14. FATHER'S NAME First: JACOB Middle: WESLEY Last: KING	15. MOTHER'S MAIDEN NAME First: ANNIE Middle: A.E. Last: MILLER		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 213-05-1710	17. INFORMANT: MRS. CARRIE KOONTZ KING Address: SAME ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): ACUTE MYOCARDIAL INFARCTION
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109
DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC CARDIOVASCULAR DIS 10 YEARS
DUE TO, OR AS A CONSEQUENCE OF (c):
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH:

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Daniel I. Weliver DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☑ STAFF PHYS. ☐	22c. DATE SIGNED: 11 JUNE 1969		
22d. PHYSICIAN'S NAME (Type): DANIEL I. WELIVER	22e. ADDRESS: WESTMINSTER MD		
23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 6/14/69	23c. NAME OF CEMETERY OR CREMATORY: MEADOW BRANCH	23d. LOCATION (City or Town) (County) (State): WESTMINSTER RD Md.
24. FUNERAL DIRECTOR: J. E. Myers Jr.	ADDRESS: Westminster, Md. 21157	25a. RECD BY REGISTRAR DATE: JUN 13 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge

VR A15 (4)
30M REV. 1/68

4 14 08237

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Items#5&6, Film G414 7/11/69 km

CERTIFICATE OF DEATH

08230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	Albert Charles KLEIN	2a. DATE OF DEATH Month / Day / Year	June 8, 1969
2b. HOUR	11 a.M.		
3. SEX	male	4. RACE	white
5. DATE OF BIRTH	10-6-83/ 1882	6. AGE (In years last birthday)	83/86 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN	
7a. BIRTHPLACE (State or foreign country)	West Virginia	7b. CITIZEN OF WHAT COUNTRY?	U.S.A.
8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]		9. COUNTY OF DEATH	Carroll Md.
10. CITY OR TOWN OF DEATH	Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Springfield State Hosp.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)	Retired Signalman R.R.	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE	Maryland	13b. CITY OR COUNTY	Washington Co.
13c. CITY OR TOWN	Hancock	13d. INSIDE CITY LIMITS? YES [X] NO [ ]	
13e. STREET AND NUMBER	Pennsylvania Ave.		
14. FATHER'S NAME First / Middle / Last	Albert Charles Klein	15. MOTHER'S MAIDEN NAME First / Middle / Last	Anna [illegible]
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	no	(If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.	705-05-1748-A	17. INFORMANT	Records
Address	Springfield State Hosp., Sykesville, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Bilateral Bronchopneumonia

DUE TO, OR AS A CONSEQUENCE OF (b) Acute & Chronic pyelonephritis

DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic heart disease

Conditions, if any, which gave rise to immediate couse (a), stoting the underlying couse last. 4123

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: (a) days (b) week (c) years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medicol examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Manth Doy Year 19

21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at wark [ ] Not while at wark [ ]

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)

21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** thot (I) (this haspital) attended the deceased from 5-27-69, 19____, to 6-8-69, 19____, thot (I) (we) lost saw the deceased alive an 6-8-69 19____, and that in (my) (our) opinion death accurred on the date and hour and fram the causes stated above, (I) (we) (did) (did not) view the body ofter deoth.

22b. SIGNATURE Octavio A Ruiz M.D. DEGREE ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [X]

22c. DATE SIGNED 6-8-69

22d. PHYSICIAN'S NAME (Type) Octavio Ruiz, M.D.

22e. ADDRESS Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town)	(County)	(State)
Burial	6-11-69	Bethel Cemetery	New Creek	W.	Va
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE		
Harry W. Haight	Sykesville, Md.	JUN 16 1969	[illegible] Judge		

VR A15 (4) 45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08238

CERTIFICATE OF DEATH

08231

1. DECEASED-NAME (Type or print): First William Middle E. Last Liden
2a. DATE OF DEATH: Month 6 Day 24 Year 69
2b. HOUR: 11:30 P.M.
3. SEX: Male
4. RACE: White
5. DATE OF BIRTH: July 6, 1897
6. AGE (In years last birthday): 71 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): Md.
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐
9. COUNTY OF DEATH: Carroll Md.
10. CITY OR TOWN OF DEATH: Sykesville
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): OAK Street
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Nursing
12b. KIND OF BUSINESS OR INDUSTRY: Hospital
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.
13b. COUNTY: Carroll
13c. CITY OR TOWN: Sykesville
13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: OAK Street
14. FATHER'S NAME: First Charlie Middle - Last Liden
15. MOTHER'S MAIDEN NAME: First Annie Middle - Last Trice
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No
(If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 218 34 0567
17. INFORMANT: Mrs. Lucy Liden Address: Sykesville, Md.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Ruptured aneurysm (abdominal aorta) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 hr.
441.2
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b) Aneurysm of abdominal aorta — 5 yrs.
DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis with hypertension — 10 yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☒
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)
21b. TIME OF INJURY HOUR A.M. P.M. Manth Day Year 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While at work ☐ Nat while at work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (I) (this hospital) attended the deceased from April 15, 19 63, to June 24, 19 69, that (I) (we) last saw the deceased alive an June 24 19 69, and that in (my) (aur) apinian death accurred on the date and haur and fram the causes stated abave, (I) (we) (did) (did nat) view the bady after death.

22b. SIGNATURE: Sani Okutman DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: June 25, 1969
22d. PHYSICIAN'S NAME (Type): Sani Okutman, M.D.
22e. ADDRESS: Obrecht Rd., Sykesville, Md. 21784

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial
23b. DATE: 6-27-69
23c. NAME OF CEMETERY OR CREMATORY: Lake View Cemetery
23d. LOCATION (City or Town) (County) (State): Sykesville, Md.
24. FUNERAL DIRECTOR: Harry W. Haight ADDRESS: Sykesville, Md.
25a. REC'D BY REGISTRAR DATE: JUN 30 1969
25b. REGISTRAR'S SIGNATURE: Charles Juiler

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08239

CERTIFICATE OF DEATH

08232

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
MARY	EVELYN	LINTHICUM	JUNE 12, 1969	9:10 AM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN
Female	White	5-1-13	56 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	Sep	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of wark done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	Springfield State Hospital	Waitress	

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Montgomery	Gaithersburg	YES X NO	427 Gaither Street

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Clarence		Poole	Unk.		

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, ar unknawn) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
No	220-26-4298	Records, Springfield State Hospital

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter anly ane cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	Hepatic failure	Years
DUE TO, OR AS A CONSEQUENCE OF		
Conditians, if any, which gave rise ta immediate cause (a), stating the underlying cause last. (b)	Cirrhosis of liver	Years
DUE TO, OR AS A CONSEQUENCE OF		
(c)	Chronic alcoholism	Years

571.0

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO X	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at wark ☐ Nat while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street ar R.F.D. Na.	City or Town	County	State

22a. **I certify** that (I) (this hospital) ottended the deceased from 5-20-69, 19____, ta 6-12-69, 19____, that (I) (we) last saw the deceased alive on 6-12-69 19____, and thot in (my) (aur) opinian death accurred on the date ond hour and from the causes stated abave, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Dr. Antonius Glahn		☐	☐	X	6-12-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Antonius Glahn, M. D.	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	June 16 1969	Laytonsville	Laytonsville Mont. MD.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Francis H. Barber Laytonsville Md	JUN 16 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08240 — 08233

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Charles	Wesley	MARTIN	June 28 1969	6:10 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS / DAYS	IF UNDER 24 HRS. HOURS / MIN.
Male	White	April 2. 1883	86 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	U.S.A.	WIDOWED ☒	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY.
Manchester	Long View Nursing Home Manchester MD	FARMER	Agriculture

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	HAMPSTEAD	YES ☐ NO ☒	108 Hanover Pike Ave

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
LEWIS		MARTIN	Mary Elizabeth		KELLER

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
NO	213-38-9455 A	EVA M. Bush HAMPSTEAD MD

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b) and (c).) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Chronic Myocarditis

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Cardio Vascular Disease

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

4124

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Advanced Emphysema Cor Pulmonare

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
—	—	YES ☐ NO ☒	—

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I **certify** thot (I) (this hospital) ottended the deceased from June, 1967, to June, 1969, thot (I) (~~we~~) lost sow the deceased olive on June 28 1969, and thot in (my) (~~our~~) opinion deoth occurred on the dote ond hour ond from the couses stoted obove, (I) (we) (did) (~~did not~~) view the body ofter deoth.

22b. SIGNATURE DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Joseph E. Bush M.D.	☒	☐	☐	June 28. 1969

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Joseph E. Bush M.D.	Hampstead Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	July 1, 1969	Grace Cemetery	Hampstead ~~Carroll~~ Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Tipton - Eline Funeral Home Hampstead, Md.	JUL 7 1969	J. Charles Judge

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08241 — 08234

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First	Lucy	Middle Ann	Last Mc Grane
2a. DATE OF DEATH Month / Day / Year	6 / 5 / 69	2b. HOUR	2:30 PM
3. SEX	Female		
4. RACE	White		
5. DATE OF BIRTH	May 31, 1900		
6. AGE (In years last birthday)	69 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country)	Virginia		
7b. CITIZEN OF WHAT COUNTRY?	USA		
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐			
9. COUNTY OF DEATH	Carroll Md.		
10. CITY OR TOWN OF DEATH	Westminster		
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	Carroll Co. Gen. Hospt.		
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Housewife		
12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Md.		
13b. COUNTY	Carroll		
13c. CITY OR TOWN	Finksburg		
13d. INSIDE CITY LIMITS? YES ☐ NO ☐			
13e. STREET AND NUMBER	Bloom Road		
14. FATHER'S NAME First	James	Middle	Last Ellis
15. MOTHER'S MAIDEN NAME First	Elizabeth	Middle	Last Paine
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	No	(If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.	219-12-9415		
17. INFORMANT Address	Mrs. Madeline Swan Finksburg, Md.		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) CEREBRAL THROMBOSIS — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 WKS.

4127 Conditions, if ony, which gove rise to immediate couse (a), stoting the underlying couse lost.

DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSIVE + ATHEROSCLEROTIC

~~DUE TO, OR AS A CONSEQUENCE OF~~ (c) CARDIOVASCULAR DISEASE — YEARS

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATIDN	19b. CDNDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY DCCURREO While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LDCATION Street or R.F.D. No.	City or Town / County / Stote

22a. **I certify** that (I) (this haspital) attended the deceased from 5/30, 1969, to 6/5, 1969, that (I) (we) last saw the deceased alive on 6/5 1969, and that in (my) (aur) opinion deoth occurred on the dote and hour and from the causes stated above, (I) (we) (did) (did nat) view the body after death.

22b. SIGNATURE	Vincent J. Fusco Jr MD	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 6/5/69
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS	

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LDCATION (City or Town) (County) (State)	
Burial	June 9, 69	New Oakland Cemetery	Sykesville, Md.	
24. FUNERAL DIRECTOR.	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
J. T. Cline & Sons	Reisterstown, Md.	JUN 9 1969		

VR A15 (A)
45M - 1-69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08242 — 08235

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

1. DECEASED-NAME (Type or print)	First: Mabel	Middle: I.	Last: MORAN	2a. DATE OF DEATH Month: June	Day: 23	Year: 1969	2b. HOUR: 4:30 P.M.
3. SEX: Female	4. RACE: White	5. DATE OF BIRTH: Nov. 15, 1887	6. AGE (In years last birthday): 81 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.				
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Springfield State	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Typist	12b. KIND OF BUSINESS OR INDUSTRY: —				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Md.	13b. COUNTY:	13c. CITY OR TOWN: Baltimore	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 2405 Hamilton Ave.			
14. FATHER'S NAME First: William	Middle: —	Last: Troutman	15. MOTHER'S MAIDEN NAME First: Amelia	Middle: —	Last: Black		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 159-10-0901	17. INFORMANT: Medical Records	Address: Springfield State Hospital Sykesville, Md.				

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Arteriosclerotic Cardiovascular Disease — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4124
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b):
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): C B S associated with senile brain disease with behavioral reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED While ☐ at work Not while ☐ at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. I certify that ☒ (this hospital) attended the deceased from March 24, 1927, to June 23, 1969, that ☒ (we) last saw the deceased alive on June 23, 1969, and that in (☒) (our) opinion death occurred on the date and hour and from the causes stated above, ☒ (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
John C. Murphy M.D.	M.D.	☐	☐	☒	6/23/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
John C. Murphy, M.D.	Springfield State Hosp Sykesville, Md

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/26/69.	Loudon Park Cemetery	Baltimore, Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Leonard J. Ruck, Inc. Balto. Md. 21214		JUN 24 1969	Charles George

VR A15 (1)
45M - 1/69

13

08243

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08236
E.S.T.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 2 and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: LLOYD Middle: OLIVER Last: MYERS		2a. DATE OF DEATH Month: June Day: 15, Year: 1969	2b. HOUR 12:15 a. M
3. SEX: M	4. RACE: W	5. DATE OF BIRTH: Aug. 10 1904	6. AGE (In years last birthday): 64 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): MD	7b. CITIZEN OF WHAT COUNTRY?: USA	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Md.
10. CITY OR TOWN OF DEATH: TANEYTOWN	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): YORK ST.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): CANNING FACTORY	12b. KIND OF BUSINESS OR INDUSTRY: LABORER
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: MD	13b. COUNTY: CARROLL	13c. CITY OR TOWN: TANEYTOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐ — 13e. STREET AND NUMBER: YORK ST
14. FATHER'S NAME First: William Middle: Last: MYERS		15. MOTHER'S MAIDEN NAME First: Margaret Middle: Last: SHOEMAKER	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO (If yes give war or dates of service): NO	16b. SOCIAL SECURITY NO.: 218-07-1406	17. INFORMANT: MARIAN I. RICKETTS Address: UNION BRIDGE	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ARTERIOSCLEROTIC HEART DISEASE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 15 yrs.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerosis Generalized — 15 yrs.

DUE TO, OR AS A CONSEQUENCE OF (c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4123

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Severe Emphysema

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. I certify that (I) (~~this hospital~~) attended the deceased from 10 April, 19 44, to 15 June, 19 69, that (I) (~~last~~) saw the deceased alive on 7 June 19 69 and that in (my) (~~his~~) opinion death occurred on the date and hour and from the causes stated above, (I) (~~he~~) (did) (~~did not~~) view the body after death.

22b. SIGNATURE: Robert S. McVaugh — DEGREE: ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 15 June '69

22d. PHYSICIAN'S NAME (Type): Robert S. McVaugh M.D. — 22e. ADDRESS: Taneytown, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: JUNE 17	23c. NAME OF CEMETERY OR CREMATORY: REFORMED CEM.	23d. LOCATION (City or Town): TANEYTOWN	(County): CARROLL (State): MD
24. FUNERAL DIRECTOR: [illegible] Sons	ADDRESS: UNION BRIDGE	25a. REC'D BY REGISTRAR DATE: JUN 19 1969	25b. REGISTRAR'S SIGNATURE: J. Charles Judge	

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08244

08237

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR ATS T4)
45M 1/69

1. DECEASED-NAME (Type or print)	First: JOHN	Middle: WESLEY	Last: NICHOLSON	2a. DATE OF DEATH Month: 06 Day: 18 Year: 69	2b. HOUR: 6:30 M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 04-15-99	6. AGE (In years last birthday): 70 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED [X] NEVER MARRIED [ ] WIDOWED [ ] DIVORCED [ ]	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Springfield State Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Farmer	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE: Maryland	13b. COUNTY: Howard	13c. CITY OR TOWN: Dayton	13d. INSIDE CITY LIMITS? YES [ ] NO [X]	13e. STREET AND NUMBER: Linthicum Road	
14. FATHER'S NAME First: John	Middle: Richard	Last: Nicholson	15. MOTHER'S MAIDEN NAME First: Sarah	Middle: Lucas	Last:
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 577-10-8112-A	17. INFORMANT: Records, Springfield State Hospital	Address		

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

4124

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Arteriosclerotic cardiovascular disease. — years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES [X] NO [ ]	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING [ ] OR CONTRIBUTING [ ] CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)	
21d. INJURY OCCURRED While at work [ ] Not while at work [ ]	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. I certify that (I) (this hospitol) attended the deceased from 12-6-66, 19____, to 6-18-69, 19____, that (I) (we) lost saw the deceased alive on 6-18-69 19____, and that in (my) (our) opinion death occurred on the dote and hour ond from the couses stated obave, (I) (we) (did) (did not) view the body ofter death.

22b. SIGNATURE: Octavio A Ruiz M.D. DEGREE	ATTENDING PHYS. [ ] MED. DIRECTOR [ ] STAFF PHYS. [ ]	22c. DATE SIGNED: 6-18-69	
22d. PHYSICIAN'S NAME (Type): Octavio Ruiz, M.D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6-20-69	23c. NAME OF CEMETERY OR CREMATORY: MT Zion	23d. LOCATION (City or Town) (County) (State): Highland Howard Md.	
24. FUNERAL DIRECTOR: Higinbotham-Slack	ADDRESS: Ellicott City Md.	25a. REC'D BY REGISTRAR DATE: JUN 20 1969	25b. REGISTRAR'S SIGNATURE	

1

08245

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08238

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or print): First WILLIAM Middle HARRISON Last OGG
2a. DATE OF DEATH: Month JUNE Day 21 Year 1969
2b. HOUR: 930 M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: JULY 5 1885
6. AGE (In years last birthday): 83 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS
IF UNDER 24 HRS.: HOURS / MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY?: UNITED STATE
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): R.F.D #6
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): FARMER
12b. KIND OF BUSINESS OR INDUSTRY:
13a. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) STATE: MD.
13b. COUNTY: CARROLL
13c. CITY OR TOWN: WESTMINSTER
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET AND NUMBER: R.F.D #6 BIRD VIEW ROAD.
14. FATHER'S NAME: First GEORGE Middle N. Last OGG
15. MOTHER'S MAIDEN NAME: First LAURA Middle FRANCES Last WILLIAMS
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): NO
(If yes give war or dates of service): —
16b. SOCIAL SECURITY NO.: 214-03-7339
17. INFORMANT: ALBERT LEPPO, Address: SAME ADDRESS

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): CONGESTIVE HEART FAILURE
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 MONTH
4124
Conditians, if ony, which gave rise ta immediate couse (a), stoting the underlying cause lost.
DUE TO, OR AS A CONSEQUENCE OF (b): ARTERIOSCLEROTIC CARDIOVASCULAR DIS
DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE ORCONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF OEATH (If either, natify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 ar Part 2, Item 18.)
21d. INJURY OCCURRED While ot wark ☐ Not while ot work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City ar Town County Stote

22a. **I certify** that (I) (this hospital) attended the deceased from JUNE, 1965, to JUNE, 1969, that (I) (we) last saw the deceased alive an JUNE 21 1969, and that in (my) (aur) apinian death accurred an the date and haur and from the causes stated abave. (I) (we) (did) (did not) view the body after deoth.

22b. SIGNATURE: Daniel I Welliver DEGREE ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 6-21-69
22d. PHYSICIAN'S NAME (Type): DANIEL I. WELLIVER
22e. ADDRESS: WEST MINSTER MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 6/24/69
23c. NAME OF CEMETERY OR CREMATORY: DEER PARK CEMETERY
23d. LOCATION (City ar Town) (County) (State): SMALLWOOD CARROLL, MD
24. FUNERAL DIRECTOR: J. E. Myers, Jr. ADDRESS: Westminster, Md.
25a. REC'D BY REGISTRAR DATE: JUN 24 1969
25b. REGISTRAR'S SIGNATURE: Charles Jaeger

VR A-15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08246 — 08239

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physicion.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First / Middle / Last	BURNETT Sullivan ORMSTON	2a. DATE OF DEATH Month Day Year	June 30 1969
2b. HOUR	7:10 AM		
3. SEX	Female	4. RACE	White
5. DATE OF BIRTH	April 12 1887	6. AGE (In years last birthday)	82 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Maryland	7b. CITIZEN OF WHAT COUNTRY?	USA.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐		9. COUNTY OF DEATH	Carroll Md.
10. CITY OR TOWN OF DEATH	HAMPSTEAD	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	218 N MAIN ST.
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Telephone Operator.	12b. KIND OF BUSINESS OR INDUSTRY	C&P Tel Co.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	Maryland	13b. COUNTY	Carroll
13c. CITY OR TOWN	HAMPSTEAD	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	
13e. STREET AND NUMBER	218 N Main Street		
14. FATHER'S NAME First / Middle / Last	HENRY Sullivan	15. MOTHER'S MAIDEN NAME First / Middle / Last	MARTHA ELLEN HOOVER
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	NO	(If yes give war or dates of service)	—
16b. SOCIAL SECURITY NO.	212-03-6446A	17. INFORMANT	Mrs Robert G Murray
Address	HAMPSTEAD MD		

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Abdominal Metastatic Carcinomatosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 7
DUE TO, OR AS A CONSEQUENCE OF (b) Primary Carcinoma of Colon. — ?
DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerosis of Colon.
153.8
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES ☐ NO ☒		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	
21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While at work ☐ Not while at work ☐		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	
21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (~~this hospital~~) attended the deceased from Feb 4, 1966, to June 30, 1969, that ~~(I)~~ (we) last saw the deceased alive on June 29 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	Joseph E Bush MD	DEGREE	ATTENDING PHYS. ☒	MED. DIRECTOR ☐	STAFF PHYS. ☐	22c. DATE SIGNED: June 30. 1969
22d. PHYSICIAN'S NAME (Type)	Joseph E Bush MD.					22e. ADDRESS: HAMPSTEAD Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)	
Burial	July 2, 1969	Hampstead Cemetery	Hampstead Carroll Md.	
24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE	
Tipton - Eline Funeral Home	Hampstead, Md.	JUL 7 1969	J Charley Judge	

VR A15 (4)
30M REV. 1/68

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08247 08240

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Margaret	Frances	Ruth	6 - 6 - 69	10:30 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years if under 1 year, months, days; if under 24 hrs., hours, min.)
female	white	5/7/83	86 YRS.

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
Maryland	USA	NEVER MARRIED [X]	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Rural--Sykesville	Springfield State Hospital	saleslady	Sales

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Md.		Baltimore	YES [X] NO [ ]	2764 The Alameda

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
XXXXXXX	David	Ruth	XXXXXXX	Mary	Hess

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	217-48-9791	Springfield Hospital records, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Congestive Heart failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days
DUE TO, OR AS A CONSEQUENCE OF
(b) Nephrosclerosis — years
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last.
403X

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) Chronic brain syndrome associated with cerebral arteriosclerosis with psychotic reaction.

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES / NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		NO [X]	

21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work / Not while at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. I certify that (this hospital) attended the deceased from 12/31/, 19 68, to 6-6, 19 69, that (we) last saw the deceased alive on 6-6 1969, and that in (our) apinion death occurred on the date and haur and from the causes stated above, (we) (did) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Glorito F. Sagisi M.D.		[ ]	[ ]	[X]	6-6-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Glorito Sagisi	Springfield State Hospital Sykesville, Maryland

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/10/69	Holy Redeemer	Baltimore Md.

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
H.W.Jenkins & Sons Co. 4905 York Road Balto.12, Md.	JUN 9 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires thot the deoth certificate be executed within 24 hours after deoth. Page 4 moy be retoined by the hospitol or ottending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers, Pages 1 and 2 should be filed with the Stote Dept. of Heolth prior to burial, cremation, or removal, and in any event, within 72 hours after deoth.

VR A15 (4)
45M - 1-68

1

08248

Item23 Film G413 6/20/69 kk

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08241

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Leo	Middle: E.	Last: St. Clair	2a. DATE OF DEATH Month: 6 Day: 13 Year: 69
2b. HOUR: 3:15 A M			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 10-26-07	6. AGE (In years last birthday): 61 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN		
7a. BIRTHPLACE (State or foreign country): Maryland	7b. CITIZEN OF WHAT COUNTRY?: United States	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: Carroll County, Md.
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address): Springfield State Hosp.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Laborer	12b. KIND OF BUSINESS OR INDUSTRY: Unkn.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Washington	13c. CITY OR TOWN: Hagerstown	13d. INSIDE CITY LIMITS? YES ☒ NO ☐
13e. STREET AND NUMBER: 315 Ridge Avenue			
14. FATHER'S NAME First: Unknown	Middle	Last	15. MOTHER'S MAIDEN NAME First: Unknown Middle Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown): No	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: None	17. INFORMANT: Springfield State Hospital records Address

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Congestive Heart Failure — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Months

093.9

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b): Syphilitic aortitis. — Years

DUE TO, OR AS A CONSEQUENCE OF (c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Chronic Brain Syndrome 2ch Neurosyphilis

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☒ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that ☒ (this hospital) attended the deceased from 9-24- , 19 41 , to 6-13 , 19 69 , that (☒ (we) last saw the deceased alive on 6-13- 19 69, and that in (☒) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (We) (did) (did not) view the body after death.

22b. SIGNATURE: Robert G. Sagisi	DEGREE: ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 6-13-69	
22d. PHYSICIAN'S NAME (Type): G. Sagisi, M.D.	22e. ADDRESS: Springfield State Hospital Sykesville, Maryland 21784		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/17/69	23c. NAME OF CEMETERY OR CREMATORY: Rest Haven Cemetery	23d. LOCATION (City or Town): Hagerstown,	(County): Wash.	(State): Md.
24. FUNERAL DIRECTOR: Kouzer F. Home	ADDRESS: Hag Md 305 N. Pot St	25a. REC'D BY REGISTRAR: JUN 17 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge		

VR A15 (2)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08249 — 08242

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4) 30M REV. 1/68

1. DECEASED-NAME (Type or print) First / Middle / Last	EMMA N Sallosto	2a. DATE OF DEATH Month / Day / Year	June 13 1969
2b. HOUR	5:15 P M		
3. SEX	female	4. RACE	White
5. DATE OF BIRTH	3/28/1894	6. AGE (In years last birthday)	74 YRS.
IF UNDER 1 YEAR: MONTHS / DAYS		IF UNDER 24 HRS.: HOURS / MIN.	
7a. BIRTHPLACE (State or foreign country)	Md Frederick Co.	7b. CITIZEN OF WHAT COUNTRY?	USA
8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐		9. COUNTY OF DEATH	Carroll Md.
10. CITY OR TOWN OF DEATH	Manchester	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	Long View Nursing Home
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	Homemaker	12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	md	13b. COUNTY	—
13c. CITY OR TOWN	Baltimore	13d. INSIDE CITY LIMITS? YES ☑ NO ☐	
13e. STREET AND NUMBER	2821 E Madison St		
14. FATHER'S NAME First / Middle / Last	Samuel Fraley	15. MOTHER'S MAIDEN NAME First / Middle / Last	Mary Simmons
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown	No	16b. SOCIAL SECURITY NO.	212-09-6462
17. INFORMANT	1) Vito Sallosto 2) 2821 E Madison St	Address	Balto Md

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Coronary Thrombosis — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 1 day

DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease — 5 yrs

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

Cirrhosis of Liver Secondary Anemia

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State	

22a. **I certify** that (I) (this hospital) attended the deceased from 6/3, 1969, to 6/13, 1969, that (I) (we) last saw the deceased alive on 6/13 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	W H Foard M.D	DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐	22c. DATE SIGNED 6/13/69
22d. PHYSICIAN'S NAME (Type)	W. H Foard MD	22e. ADDRESS	Manchester, Md 21102

23a. BURIAL, CREMATION, REMOVAL (Specify)	Burial	23b. DATE	6-17-69	23c. NAME OF CEMETERY OR CREMATORY	Baltimore Memorial Cemetery
23d. LOCATION (City or Town) (County) (State)	Balto. Md.				
24. FUNERAL DIRECTOR	Philip E. Grach	ADDRESS	1211 Chestnut Ave	25a. REC'D BY REGISTRAR DATE	JUN 17 1969
25b. REGISTRAR'S SIGNATURE	Charles Judge				

1

4

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

99 06 1

4109

2

2

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

08250

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

08243

1. DECEASED-NAME (Type or Print) First: BERNARD	Middle: PAUL	Last: SANDERS	2a. DATE OF DEATH KNOWN ☒ ESTIMATED ☐ Month: 6 Day: 21 Year: 1969	2b. HOUR: 1:45 P M			
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 9/25/1911	6. AGE (In years last birthday): 57 YRS. IF UNDER 1 YEAR: MONTHS / DAYS IF UNDER 24 HRS: HOURS / MIN.	2c. DATE PRONOUNCED DEAD Month: 6 Day: 21 Year: 1969	2d. HOUR: 3:30 P M		
7a. BIRTHPLACE (State or foreign country): Carroll Co. Md.	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☒	9. COUNTY OF DEATH: Carroll Md.				
10. CITY OR TOWN OF DEATH: Westminster	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): D.O.A. Carroll Co. General Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Millwork	12b. KIND OF BUSINESS OR INDUSTRY: Mill				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Carroll	13c. CITY OR TOWN: Westminster	13d. INSIDE CITY LIMITS? YES ☐ NO ☒	13e. STREET AND NUMBER: R. D. 1			
14. FATHER'S NAME First: John	Middle: J.	Last: Sanders	15. MOTHER'S MAIDEN NAME First: Annie	Middle: S. Watson	Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): No (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 181-07-3171	17. INFORMANT: Z. W. Sanders	ADDRESS: Circle Drive R. D. 1 Carlisle, Pa. 17013				

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis (acute) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
DUE TO, OR AS A CONSEQUENCE OF
(b):
DUE TO, OR AS A CONSEQUENCE OF
(c):
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4109

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	20. AUTOPSY? YES ☐ NO ☒
21a. EXTERNAL CAUSE WAS PRIMARY ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH	21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
21d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐	21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f. LOCATION Street or R.F.D. No. / City or Town / County / State

22a. **I certify** that I took charge of the remains described above, held on Autopsy ☐, Inspection ☒, Inquiry ☐, and in my opinion death resulted from: Natural causes ☒, Accident ☐, Suicide ☐, Homicide ☐, Undetermined manner ☐

ACTUAL SIGNATURE: W. Glenn Speicher M.D.
CHIEF MEDICAL EXAMINER ☐
ASSISTANT MEDICAL EXAMINER ☐
DEPUTY MEDICAL EXAMINER ☒
EXAMINER'S NAME (Type)
ADDRESS (Street, City, County, or County)

22b. DATE SIGNED: 6-21-69

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County)
Burial	6/25/69	St. Aloysius Cemetery	Littlestown, Adams Co. Pa.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Richard S. Little	Littlestown, Pa.	JUN 25 1969	Charles Judge

VR A15ME (5)
1DM REV. 1/68

3 1

08251

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08244

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print) First: Joseph Middle: Alden Last: Schissell SCHIESSL				2a. DATE OF DEATH Month Day Year: 6-8-69	2b. HOUR: 11:00 P M
3. SEX: Male	4. RACE: White	5. DATE OF BIRTH: 8-5-89	6. AGE (In years last birthday): 87 77 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
7a. BIRTHPLACE (State or foreign country): Wisconsin	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☒ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.		
10. CITY OR TOWN OF DEATH: Sykesville	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): Springfield St. Hospital	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Retired	12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: Maryland	13b. COUNTY: Montgomery	13c. CITY OR TOWN: Potomac	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER: 10,000 Carmelita Drive	
14. FATHER'S NAME First Middle Last: Joseph Schissell		15. MOTHER'S MAIDEN NAME First Middle Last: Margaret YEAGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): None (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 327-07-0860	17. INFORMANT Address: Springfield St. Hospital Records, Sykesville, Md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Bronchopneumonia — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: days

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 437.9

DUE TO, OR AS A CONSEQUENCE OF (b): Uremia — days

DUE TO, OR AS A CONSEQUENCE OF (c): Generalized arteriosclerosis — yrs.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): CBS assoc. with cerebral arteriosclerosis with psychotic reaction

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County Stote	

22a. **I certify** that (this hospital) attended the deceased from 4-29-69, 19____, to 6-8-69, 19____, that (I) (we) last saw the deceased alive on 6-8-69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. I (we) (did) (did not) view the body after death.

22b. SIGNATURE: Jose A. Raquel Jr. M.D. DEGREE	ATTENDING PHYS. ☐ MED. DIRECTOR ☐ STAFF PHYS. ☒	22c. DATE SIGNED: 6-8-69	
22d. PHYSICIAN'S NAME (Type): Jose A. Raquel, Jr. M.D.	22e. ADDRESS: Springfield St. Hospital, Sykesville, Md.		

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6-12-69	23c. NAME OF CEMETERY OR CREMATORY: Holy Sepulchre Cem	23d. LOCATION (City or Town) (County) (State): Oakland, Md.	
24. FUNERAL DIRECTOR: W. W. Chambers Co. ADDRESS: 1400 Chapin St. N.W. Wash. D.C.	25a. RECD BY REGISTRAR DATE: JUN 12 1969	25b. REGISTRAR'S SIGNATURE: Charles Jenge		

VR A15 (4)
45M - 1/69

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08252 08245

1. DECEASED-NAME (Type or print): First OLIVER Middle CORNELIUS Last SHOLL
2a. DATE OF DEATH: Month 6 Day 21 Year 69
2b. HOUR: 7:00 M
3. SEX: MALE
4. RACE: WHITE
5. DATE OF BIRTH: NOV. 4, 1882
6. AGE (In years last birthday): 86 YRS. IF UNDER 1 YEAR: MONTHS DAYS IF UNDER 24 HRS.: HOURS MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND
7b. CITIZEN OF WHAT COUNTRY? U.S.A.
8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐
9. COUNTY OF DEATH: CARROLL Co. Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street oddress): R.F.D #4
12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): CARETAKER
12b. KIND OF BUSINESS OR INDUSTRY: STATE HOSP'L
13a. USUAL RESIDENCE (Where deceosed lived, if institution: Residence before odmission) STATE: MARYLAND
13b. COUNTY: CARROLL
13c. CITY OR TOWN: WESTMINSTER
13d. INSIDE CITY LIMITS? YES ☐ NO ☑
13e. STREET AND NUMBER: R.F.D. #4 CRANBERRY
14. FATHER'S NAME First JOHN Middle W. Last SHOLL
15. MOTHER'S MAIDEN NAME First REBECCA Middle ERB Last
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: NO (If yes give war or dates of service)
16b. SOCIAL SECURITY NO.: 219-12-0562
17. INFORMANT: MISS HELEN H. SHOLL Address: WESTMINSTER RT#2 MD.

MEDICAL CERTIFICATION

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a): Coronary Thrombosis (acute) — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Sudden
4100
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
DUE TO, OR AS A CONSEQUENCE OF (b): Hypertension + Arteriosclerotic 4 yrs
DUE TO, OR AS A CONSEQUENCE OF (c): Cardio Vascular Disease
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
20a. AUTOPSY? YES ☐ NO ☑
20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)
21b. TIME OF INJURY HOUR A.M. P.M. Month Doy Yeor 19
21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)
21d. INJURY OCCURRED While ot work ☐ Not while ot work ☐
21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
21f. LOCATION Street or R.F.D. No. City or Town County Stote

22a. I certify that (I) (this hospital) attended the deceased from 1-22 1964, to 6-21, 1964, that (I) (we) last saw the deceased alive on 6-7-64 1964, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: Wglenn Speicher M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐
22c. DATE SIGNED: 6-21-64
22d. PHYSICIAN'S NAME (Type): W. GLENN SPEICHER M.D.
22e. ADDRESS: E. MAIN ST. WESTMINSTER, MD

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL
23b. DATE: 6/24/69
23c. NAME OF CEMETERY OR CREMATORY: ST MARY'S CEMETERY
23d. LOCATION (City or Town) (County) (Stote): SILVER RUN, CARROLL, MD.
24. FUNERAL DIRECTOR: J. S. Myers Jr. ADDRESS: Westminster, Md 21157
25a. RECD BY REGISTRAR DATE: JUN 24 1969
25b. REGISTRAR'S SIGNATURE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A 15 (4)
30M REV. 1/68

1

08253

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08246

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours of death.

VR A15 (1) 45M - 4/69

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR	
GODFREY	BERNARD	SMITH	JUNE 6-, 1969	7:15 PM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN
Male	White	7-31-02	66 YRS.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☐ NEVER MARRIED ☒ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH		
Maryland	U.S.A.		Carroll Md.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY		
Sykesville	Springfield State Hospital	Unknown			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES ☒ NO ☐	13e. STREET AND NUMBER	
Maryland	Baltimore City	Baltimore		307 Sharp Street (?)	
14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Bernard		Smith	Annie		Burns
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address			
No	217-32-8089	Records, Springfield State Hospital			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Gangrene of both feet — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: Weeks

4450

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF (b) Severe occlusive arteriosclerotic peripheral — Month

DUE TO, OR AS A CONSEQUENCE OF (c) vascular disease

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) CBS assoc. with alcohol intoxication, without qualifying phrase

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☒	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 10-18-54, 19____, to 6-6-69, 19____, that (I) (we) last saw the deceased alive on 6-6-69 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Octavio A Ruiz M.D.		☐	☐	☒	6-8-69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Octavio A. Ruiz, M.D.	Springfield State Hospital Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6-16-69	Mt. Cathedral Cemetery	Baltimore Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Knight & Hall	Sykesville Md.	JUN 18 1969	

4 1

08254

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08247

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month	Day	Year	2b. HOUR
Ernest	Wilmer	Stewart, Sr.	6	25	69	3:05 PM

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS	IF UNDER 1 YEAR DAYS	IF UNDER 24 HRS. HOURS	IF UNDER 24 HRS. MIN
Male	White	7/23/1889	79 YRS.				

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH
Carroll Co. Md.	U.S.A.		Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Westminster	Carroll Co. General Hosp.	Retired Farmer	Farm

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	Westminster	YES ☐ NO ☒	R. D. 1 21157

14. FATHER'S NAME First	Middle	Last	15. MOTHER'S MAIDEN NAME First	Middle	Last
Joshua		Stewart	Ida		Crowl

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address 21157
No	219-20-4467	Mrs. Elvira V. Stewart, Westminster, Md. R-1

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART 1. DEATH WAS CAUSED BY:

		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a)	ACUTE MYOCARDIAL INFARCTION	7 MO.
DUE TO, OR AS A CONSEQUENCE OF (b)	ATHEROSCLEROTIC CORONARY HEART	
DUE TO, OR AS A CONSEQUENCE OF (c)	DISEASE	YEARS

4109

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

RHEUMATIC HEART DISEASE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State

22a. **I certify** that (I) (this hospital) attended the deceased from 5/23, 1969, to 6/25, 1969, that (I) (we) last saw the deceased alive on 5/25 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	ATTENDING PHYS.	MED. DIRECTOR	STAFF PHYS.	22c. DATE SIGNED
Vincent J. Riccio Jr	MD	☑	☐	☐	6/25/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6/27/69	St. Marys Cemetery	Silver Run, Carroll Co. Md.

24. FUNERAL DIRECTOR	ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
Richard A. Little	Littlestown, Pa.	JUN 27 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1) 45M - 1-68

4109 60 06 1 2 1 18

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08255 — 08248

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First: James	Middle: B	Last: Wheeler	2a. DATE OF DEATH Month: June	Day: 25	Year: 1969	2b. HOUR: 9:15 P M
3. SEX: male	4. RACE: white	5. DATE OF BIRTH: Nov 21, 1888	6. AGE (In years last birthday): 80 YRS.	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.		
7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY? USA.	8. MARRIED ☐ NEVER MARRIED ☐ WIDOWED ☑ DIVORCED ☐	9. COUNTY OF DEATH: Carroll Md.				
10. CITY OR TOWN OF DEATH: Manchester, md.	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): Longview Nursing Home Inc. 425 N. Main St. Manchester	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): Housewife	12b. KIND OF BUSINESS OR INDUSTRY: self employed.				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE: md	13b. COUNTY: carroll	13c. CITY OR TOWN: Greenmount	13d. INSIDE CITY LIMITS? YES ☐ NO ☐	13e. STREET AND NUMBER: none.			
14. FATHER'S NAME First: William	Middle: T.	Last: Wheeler	15. MOTHER'S MAIDEN NAME First: Henrietta	Middle: W.	Last: Smallwood		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown: no	(If yes give war or dates of service)	16b. SOCIAL SECURITY NO.: 218-09-1104.	17. INFORMANT (daughter) Address: Mrs. Charles Hersh	Greenmount, md.			

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): Cerebrovascular Accident — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 9 days

DUE TO, OR AS A CONSEQUENCE OF

(b): Cerebral Arteriosclerosis — 2 yrs

DUE TO, OR AS A CONSEQUENCE OF

(c):

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 437.9

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☑	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)

21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19

21c. HOW INJURY Ooccurred (Enter nature of injury in Part 1 or Part 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐

21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)

21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from Sept, 1950, to June 25, 1969, that (I) (we) last saw the deceased alive on June 24 1969, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE: W H Foard — DEGREE: ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 6/25/69

22d. PHYSICIAN'S NAME (Type): W. H Foard M.D — 22e. ADDRESS: Manchester Md.

23a. BURIAL, CREMATION, REMOVAL (Specify): Burial	23b. DATE: 6/28/69	23c. NAME OF CEMETERY OR CREMATORY: Greenmount Cemetery	23d. LOCATION (City or Town) (County) (State): Greenmount, Md. Carroll Md.	
24. FUNERAL DIRECTOR: John E. Goff Funeral Home	ADDRESS: 324 N. Main Street Hampstead, Maryland	25a. REC'D BY REGISTRAR DATE: JUN 30 1969	25b. REGISTRAR'S SIGNATURE: Marion Cudde	

VR A15 (4) 30M REV. 1-68

14 08256

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

08249

1. DECEASED-NAME (Type or print) First	Middle	Last	2a. DATE OF DEATH Month Day Year	2b. HOUR
Willie	Pinkley	Wilson	June 1, 1969	12 P M

3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR: MONTHS / DAYS	IF UNDER 24 HRS.: HOURS / MIN.
Male	White	June 17, 1890	78 YRS.		

7a. BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED / NEVER MARRIED / WIDOWED / DIVORCED	9. COUNTY OF DEATH
North Carolina	U. S. A.	MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	Carroll Md.

10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospitol give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	12b. KIND OF BUSINESS OR INDUSTRY
Sykesville	R 3, Box 388	Farmer	Agriculture

13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER
Maryland	Carroll	Sykesville	YES ☒ NO ☐	

14. FATHER'S NAME First Middle Last	15. MOTHER'S MAIDEN NAME First Middle Last
Eli Pinkley Wilson	Mary Corey

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) (If yes give war or dates of service)	16b. SOCIAL SECURITY NO.	17. INFORMANT Address
no	237-24-5154	Mrs. W. P. Wilson, R 3, Box 388, Sykesville, Md.

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one couse per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) A S H D, Coronary throbosis, Cerebral vascular

DUE TO, OR AS A CONSEQUENCE OF (b) accident, Arteriosclerosis, generalized, Cardiac failure.

DUE TO, OR AS A CONSEQUENCE OF (c)

Conditions, if any, which gave rise to immediate couse (a), stating the underlying couse last. 4109

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 2 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
		YES ☐ NO ☒	

21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medicol exominer)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Port 1 or Port 2, Item 18.)

21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State

22a. **I certify** that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated obove, (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE	DEGREE	22c. DATE SIGNED
Howard E Hall M.D.	ATTENDING PHYS. ☒ MED. DIRECTOR ☐ STAFF PHYS. ☐	6/2/69

22d. PHYSICIAN'S NAME (Type)	22e. ADDRESS
Howard E. Hall, M. D.	Sykesville, Maryland 21784

23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (City or Town) (County) (State)
Burial	6-4-69	Pinewood Memorial Park	Greenville, Pitt NC

24. FUNERAL DIRECTOR ADDRESS	25a. REC'D BY REGISTRAR DATE	25b. REGISTRAR'S SIGNATURE
S. G. Wilkerson & Sons, Greenville, NC	JUN 23 1969	Charles Judge

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospitol or attending physician.

TO FUNERAL DIRECTOR: After this certificate hos been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use os the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removol, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

Items 4,5 Film G
7/1/69 11w

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

08257

08250

1. DECEASED-NAME (Type or print) First: JOHN Middle: LEE Last: WOODYARD	2a. DATE OF DEATH Month: 6 Day: 22 Year: 69	2b. HOUR: 10:25 AM/PM	
3. SEX: MALE	4. RACE: WHITE ~~Negro~~	5. DATE OF BIRTH: DEC 15 1895	6. AGE (In years last birthday): 73 YRS. IF UNDER 1 YEAR: MONTHS, DAYS IF UNDER 24 HRS.: HOURS, MIN.
7a. BIRTHPLACE (State or foreign country): MARYLAND	7b. CITIZEN OF WHAT COUNTRY?: U.S.A.	8. MARRIED ☑ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐	9. COUNTY OF DEATH: CARROLL Co. Md.
10. CITY OR TOWN OF DEATH: WESTMINSTER	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address): CARROLL CO. GEN. HOSP.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.): GROWER FLORIST	12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived; if institution: Residence before admission) STATE: MD.	13b. COUNTY: CARROLL	13c. CITY OR TOWN: WESTMINSTER	13d. INSIDE CITY LIMITS? YES ☑ NO ☐
13e. STREET AND NUMBER: 300 E. GREEN ST.			
14. FATHER'S NAME First: MARTIN Middle: LUTHER Last: WOODYARD	15. MOTHER'S MAIDEN NAME First: AUGUSTUA Middle: Last: SQUIRREL		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown): NO (If yes give war or dates of service): —	16b. SOCIAL SECURITY NO.: 215-20-9695	17. INFORMANT: MRS. JOHN L. WOODYARD Address: SAME ADDRESS	

MEDICAL CERTIFICATION

18. **CAUSE OF DEATH** (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a): ACUTE RENAL FAILURE — APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 12 HOURS

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

(b): MULTIPLE MYELOMA — WEEKS

DUE TO, OR AS A CONSEQUENCE OF

(c):

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES ☐ NO ☐	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING ☐ OR CONTRIBUTING ☐ CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. P.M. Month Day Year 19	21c. HOW INJURY OCCURRED (Enter noture of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While at work ☐ Not while at work ☐	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State	

22a. **I certify** that (I) (this haspital) ottended the deceased from 6/20, 19 69, to 6/22, 19 69, that (I) (we) last saw the deceased alive an 6/22 19 69, and that in (my) (aur) apinian death accurred on the date and hour and fram the couses stoted obave. (I) (we) (did) (did nat) view the body after deoth.

22b. SIGNATURE: Vincent J. Fiocco Jr. M.D. — ATTENDING PHYS. ☑ MED. DIRECTOR ☐ STAFF PHYS. ☐ — 22c. DATE SIGNED: 6/22/69

22d. PHYSICIAN'S NAME (Type): VINCENT J. FIOCCO, JR. MD — 22e. ADDRESS: ANCHOR ST. WESTMINSTER MD.

23a. BURIAL, CREMATION, REMOVAL (Specify): BURIAL	23b. DATE: 6/25/69	23c. NAME OF CEMETERY OR CREMATORY: FAIRVIEW CEMETERY	23d. LOCATION (City or Town): FREDERICK MD.	(County) (State)
24. FUNERAL DIRECTOR: J. L. Myers Jr.	ADDRESS: Westminster, Md.	25a. REC'D BY REGISTRAR DATE: JUN 24 1969	25b. REGISTRAR'S SIGNATURE: Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
45M - 1/69